SMALL BUSINESS Association of MICHIGAN

Senate Insurance Committee
September 27, 2012

Chairman Hune and members of the Senate Insurance Committee, thank you for the opportunity to speak today. My name is Scott Lyon, and I am Senior Vice President of the Small Business Association of Michigan. We are a state based trade association representing over 16,000 small businesses from across Michigan. We have members with one employee to 499 employees from every type of business and in every Michigan County. We offer small group health insurance programs that cover nearly 100,000 Michiganders. Through our small business services area we are the administrators of a variety of health insurance programs, as well as Health Savings Accounts and Health Reimbursement Arrangements, Section 125 and COBRA administration. All the services we offer are intended to lower the cost and administrative hurdles that many times get in the way of offering high quality and competitive health insurance. We have years of experience at the intersection of group health insurance, small business and government relations.

We think it is important to recognize that while this specific proposal from Gov. Snyder is new, this conversation started over a decade ago with small group market reform and has continued over the years. We believe that the timing is right for this legislation and we applaud the governor for jumpstarting this conversation. Our evaluation and support of this proposal is based upon how it affects small businesses and the cost and availability of health insurance in the small group market.

Our members have told us for years that one of the greatest challenges to small business success is the high cost of health insurance. There has been a steady decline for small employers in their ability to offer health insurance to their employees. Today fewer than 50% of small employers can afford to offer health insurance to their workforce. The reason in not the availability of plans, it is premium cost. Health insurance is simply too expensive for many small businesses to afford. We are encouraged that this legislation will drive Michigan toward a level playing field for BCBSM, commercial insurers and HMO's, will streamline the outdated insurance regulatory system and offer some relief from premium increases.

Whether you are a fan of the Affordable Care Act or not, and SBAM is not a fan, you must recognize that the Act results in all carriers (BCBSM, HMOs, commercial insurers) being treated the same regarding rating and underwriting practices. All carriers can only use a 3:1 rate band, and can only price their products based on age, geography and whether or not someone smokes. More significantly, under the ACA, BCBSM will shed the designation as Michigan's "insurer of last resort" because the Act results in guaranteed issue and guaranteed renewal of insurance products and no pre-existing condition clauses for all carriers. So in many ways, without a change in the way it is governed, BCBSM would have a huge advantage if they got to shed the role of "insurer of last resort" and retain their ability to not pay taxes. Rather than level the playing field, inaction would result in a rather large distortion of the market.

With large market share and many of our members being insured by BCBSM it is important to SBAM that BCBSM remains competitive. Please keep in mind that our members don't negotiate with health care providers; they do expect BCBSM to use its size to their advantage in negotiating with providers to get the best possible prices and turn those negotiations into the best premium prices available. As Commissioner Clinton stated last week, the current rate review process is very different for BCBSM versus that of the commercial carriers and HMOs doing business in this state. The process of getting rates approved is much longer for BCBSM than it is for their competitors. Adherence to the Affordable Care Act, placing products on the Exchange and the Essential Health Benefits requires a much more streamlined process.

The proposal in front of you turns BCBSM into a nonprofit mutual insurer with an estimated annual tax bill of $100 million and has BCBSM contribute $1.5 billion over 18 years to a separate non-profit organization with an independent Board of Directors that will oversee how that money will be spent – it looks like it could have tremendous potential to make an impact on critical health care challenges that Michigan faces. But we'd also like to make another point. Last week, there were several questions as to how that money will be spent, and while that is a fair question, there is another question that should be examined – **where does that money come from?** We believe that much of the money that BCBSM holds in reserve and would be available for this new non-profit has come from the premiums our members have paid. While some are calling for even more to be contributed by BCBSM, we are hopeful that the amount was carefully determined to ensure it would not raise rates for our members that happen to be BCBSM customers. BCBSM must maintain adequate reserves and more money sent to the new nonprofit would have to come from somewhere, and that somewhere is small business and other BCBSM fully-insured customers. These are the very same customers that can least afford additional premium increases.

With cost being the number one problem small businesses encounter daily in providing health insurance for their employees and family members, we do not want an unintended consequence of this contribution to a new nonprofit to be an increase in costs for our members and be a disincentive for job providers to offer coverage for their employees. Please keep in mind that BCBSM reserves, at least in part, used to be called something different – our members money. Reserves are what are left over following the payment of claims and administrative expenses.

Honestly, we do not want this process to repeat the unfairness of the Medigap issue from late last year where small businesses are forced to subsidize seniors to the tune of about $200 million a year. Commissioner Clinton touched on this last week and about a year ago SBAM commissioned a study of this very topic by Dr. Gary Wolfram and his Hillsdale Policy Group. A copy of that study is attached to my written testimony. Let me call your attention to the second paragraph of Dr. Wolfram's study:

"While this legislation may have been well intended, it has unintended consequences that result in increased costs on other sectors of the insurance market, in particular small business, with a resulting drag on Michigan's economy. Any amount of BCBSM earned subscription income that must be used to subsidize Medigap coverage of senior citizens cannot be used to lower the premium of the small business owner who is providing health insurance for her employees…

Here is something to think about with regard to that subsidy and any future dollars set aside:

The subsidy is to Medigap coverage – by definition Medigap is supplemental coverage that fills in the gaps of what Medicare does not already pay for. Medicare starts out at a plan of about 80%/20% and Medigap reduces the deductibles and co-insurance amounts.

BCBSM is roughly a $20 billion business

The Medigap subsidy is based upon "earned subscription income" – whatever that is…

The subsidy in dollars is roughly $200 million a year or 1% of the total dollars that flow into and out of BCBSM.

But, BCBSM does not collect $20 billion in premiums. With a large self-insured population it only collects about $6.5 billion in premiums from the small group and individual lines of coverage. The rest are the claims payments on behalf of large self-insured companies. These are a pass through.

BCBSM does not collect the 1% subsidy on the $12 - $13 billion that flows through for the self-insured.

So, to get $200 million in subsidy dollars we believe that it really takes about 3% in the rates of small group and individual premiums ($6.5 billion X 3%).

So, what started out as a 1% subsidy has turned into something very different. It has turned into the small business community paying additional premiums to subsidize coverage for seniors who are getting better coverage than what the small business is able to provide to their own employees. That is blatantly unfair.

Given that, if there is going to be money sent to this new non-profit, we believe that small business customers must have a voice in the new company. We also believe that it would be easy to spend those dollars subsidizing coverage for seniors or kids, but that does not make the cost of coverage decrease or make the market work any better, it simply lowers the cost for one or two chosen groups of people at the expense of another.

We would like to see the money sent to this new non-profit make a real difference. For example, it could fund an effort to measure the cost and the quality of hospital and ambulatory surgical centers across the state. This would be comparative, risk adjusted data on outcomes – a measurement based on cost and quality of the care being delivered based on factors like the length of stay, mortality, hospital acquired infections, re-admission rates and things of that nature. This would be a report on who is doing what better than their competitors and at what cost? Making this information available, in an understandable way, would be, in our opinion, a step in the right direction toward providing information that will help improve care and control costs.

Last, it will come as no surprise to anyone on this committee that SBAM is not a fan of mandated benefits. The $1.5 billion could also fund a mandated benefit review commission that would provide legislators with an independent cost benefit analysis of the mandates that are on the books now and any future mandated benefit proposals.

Both of these ideas are in place in other states.

To wrap up, we thank Gov. Snyder and his staff for recognizing the timing and need for this legislation, for your due diligence and for the opportunity to speak here today. I would be happy to answer any questions you might have at this time.

BCBSM Medigap Subsidies: Unintended Consequences

Gary Wolfram, Ph.D.

January 2012

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BCBSM Medigap Subsidies: Unintended Consequences

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Executive Summary

When Act 350 of 1980 was passed, Section 609 allowed Blue Cross Blue Shield of Michigan (BCBSM) to use up to one percent of its earned subscription income to subsidize the Medigap policy premiums of senior citizens. However, since the rates that BCBSM are able to set must be approved by the Commissioner of the Office of Financial and Insurance Regulation (OFIR), the amount of this subsidy to seniors who qualify for Medicare is effectively determined not by BCBSM, but rather by the Commissioner. In the past, the Commissioner has chosen to regulate the rates of BCBSM in such a way that the subsidy has been at the maximum, effectively one percent of the BCBSM revenue.

While this legislation may have been well intended, it has unintended consequences that result in increased costs on other sectors of the insurance market, in particular small businesses, with a resulting drag on Michigan's economy. Any amount of BCBSM earned subscription income that must be used to subsidize the Medigap coverage of senior citizens cannot be used to lower the premium of the small business owner who is providing health insurance for her employees, or the person who has lost his job and must seek out individual coverage, or any of the other policyholders of BCBSM. In effect Michigan small business, which is facing difficulties in trying economic times, has been subsidizing Medigap coverage for all manner of retirees.

The subsidy for seniors is ill-targeted since it has been available to seniors who have higher incomes and who may not even live in Michigan. Although the Commissioner has recently allowed BCBSM to provide subsidies based upon certain factors, such as Michigan residency, the amount of subsidy and which seniors qualify must be re-determined with every rate request. The subsidy can easily work in the opposite direction—making it more difficult for those of low income to obtain health insurance—because BCBSM revenue is diverted to subsidizing seniors.

In addition, even if keeping premiums low for people because they are old enough to qualify for Medicare made sense, there is no need to require BCBSM to provide a subsidy. A quick internet search will reveal that there are several Medicare plans offered by competing insurers that have lower premiums than those offered by BCBSM even after the required subsidy.

In addition, we should be clear that the subsidy is for coverage beyond what Medicare covers. Medicare covers 80% of approved expenses, so seniors who do not purchase Medigap coverage at all are not left without insurance. Medicare recipients may also obtain Medicare Advantage plans that provide basic Medicare coverage and additional services. These plans were not available when Section 609 was enacted. Nor was Medicare Part D, the prescription drug plan, available. Given the changes in Medicare over the past fifteen years, the required subsidy to senior citizens is not only ill-targeted by unwarranted.

Rather than requiring the subsidization of Medigap coverage of senior citizens who may have higher incomes and lesser need for subsidy than individuals or small businesses, the Legislature and OFIR Commissioner should allow the board of directors of BCBSM to decide how to serve its mission as a non-profit provider of health insurance in Michigan. This will result in lower premiums for individual and small business and a stronger Michigan economy.

I. Background Introduction

A. Blue Cross Blue Shield of Michigan[1]

The thirty-nine companies that currently comprise the Blue Cross Blue Shield Association have their origins in a teacher-based system of pre-paid hospitalization organized by the President of Baylor University, Justin Kimball, in 1929. In response to the inability of teachers and others to pay for hospital care and financial problems at Baylor University's hospital, Kimball devised a program whereby teachers would be guaranteed 21 days of hospital care per year at the University hospital and a discount on the other days in return for a monthly payment of 50 cents. This plan was adopted by the teachers and other employer groups around Dallas. Soon the concept spread throughout the country under the Blue Cross symbol. Blue Cross was a plan whereby an association would contract with hospitals to accept patients for hospitalization and would contract with subscribers to receive a monthly payment. The goal was to stabilize hospital revenues and provide the ability of subscribers to obtain hospital care.

During the Great Depression the hospitals found themselves in financial difficulty as patients could not afford hospital care. The Blue Cross plans were able to reduce the problems associated with this by providing a stable source of funds to hospitals and guaranteed access for patients. However, these plans created a legal problem. Were these associations insurance companies and thus subject to asset and reserve requirements that bound insurance companies under state law? If so, then they would not be viable since the associations did not have the required amounts of capital to start up and the hospitals were generally non-profit entities that weren't interested in becoming a mutual or stock company.

Rather than imposing the same solvency standards that applied to insurance companies, New York enacted legislation in 1935 that allowed for the creation of health service associations outside of the insurance law. The boards of the companies were to be made up of representatives of the hospitals, and the rates were subject to regulation by the insurance commissioner. The success of the New York statue led other states to follow suit.

In 1938, the Michigan Hospital Association led the drive to enact Michigan's first statute allowing the formation of a Blue Cross association in Michigan, the Michigan Hospital Service. Two enabling acts were passed in 1939, one to allow the formation of an association for prepaid hospital care and one for prepaid physician care as a mechanism for providing a flow of funds to

[1] [1]For a history of Blue Cross and Blue Shield nationally and in Michigan see S. Payton and R. Owsner, "Regulation Through the Looking Glass: Hospitals, Blue Cross, and Certificate of Need," *Michigan Law Review*, Vol. 79, December 1980, pp. 203-277, and R. Cunningham III and R. Cunningham, Jr., *The Blues: A History of the Blue Cross and Blue Shield System*, (De Kalb: Northern Illinois Press, 1997)

medical service providers and keeping medical care costs reasonable.[2] These acts required the Michigan Hospital Service to be a non-profit organization. The program was so successful that by 1941, after enrolling the employees of the automobile companies, Michigan had the second largest association in the United States

In 1974 the Legislature enacted legislation that allowed for the consolidation of Blue Cross (hospital) and Blue Shield (physician) corporations and altered the composition of the boards in response to the political conditions of the time. In 1980, the Legislature passed PA 350 which among other things substantially altered the composition of the board of BCBSM to shift control towards the subscribers.

The end result of this legislative history is that BCBSM is a non-profit corporation that is regulated by its own statute, PA 350 of 1980, rather than being regulated under the Insurance Code[3] as are other insurance companies.

B. Medigap[4]

Medicare is the federal government health insurance program that covers persons who are 65 years old and over and those under 65 with certain disabilities and those with permanent kidney failure. Medicare Part A helps cover in-patient hospital care, skilled nursing care, hospice, and some home health care. Medicare Part B helps cover doctor's services, out-patient hospital care, and some home health care. It also covers many preventative services. Medicare Part D is a prescription drug option that is run by Medicare-approved private insurance companies.

Medicare Advantage Plans, also called Medicare Part C, are health care plans run by Medicare-approved private insurance companies. These plans include Medicare Part A and B and usually other coverage such as Part D, sometimes for an extra premium cost.

A Medigap policy, also known as Medicare Supplemental Insurance, is a policy provided by private health insurance companies that will pay certain costs that Medicare doesn't cover. These would include copayments, coinsurance and deductibles. This is different from a Medicare Advantage Plan in that Medicare Advantage is a way of obtaining Medicare benefits along with other benefits, whereas a Medigap policy is a policy separate from the Medicare policy.

Medigap policies follow state and federal laws. In most states, including Michigan, Medigap policies are standardized along several levels. Each company that offers a particular level of Medigap policy must offer the same benefits. In some states, insurance companies may offer a lower cost Medigap Select plan that requires you to use doctors and hospitals within its network.

[2] 1939 PA 108 and 109.
[3] 1956 PA 218.
[4] For a more detailed description of Medigap see, Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare, 2011, Center for Medicare and Medicaid Services and National Association of Insurance Commissioners

Persons who purchase a Medigap policy must be enrolled in Medicare Parts A and B and pay the Medicare Part B premium. Medigap policies sold after January 1, 2006 do not offer prescription drug coverage. This coverage is offered under Medicare Part D.